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MEDICAID MEMO

Last Updated: 03/09/2022

Clarification of Inpatient Hospital Admissions vs. Observation

The purpose of this memorandum is to notify hospital providers of appropriate billing procedures related to hospital observations and inpatient admissions. DMAS has been encountering increasing numbers of billing and documentation errors related to hospital observations and inpatient admissions. This memo notifies providers of proper billing practices that must be followed. Patterns of inappropriate billing or documentation may be referred to the Medicaid Fraud Control Unit for investigation.

Hospital Observation:

A hospital observation is defined in the Hospital Manual, Chapter 4, pages 12-14:

> Observation services are those services furnished on a hospital's premises, including the use of a bed and periodic monitoring by a hospital's nursing or other staff, which are reasonable and necessary to evaluate an outpatient's condition or determine the need for a possible admission to the hospital as an inpatient. Such services are covered only when provided by the order of a physician or another individual authorized by state licensure law and hospital staff bylaws to admit patients to the hospital or to order outpatient tests.

A hospital may bill for observation bed services (discussed in Chapter 4 of the Hospital Manual) for **up to 23 hours**. A patient stay of 24 hours or more will require inpatient precertification where applicable.

Orders for observation services must be written prior to initiation of the service, as documented by a dated and timed order in the patient's medical record. The order may not be backdated. Orders should be clear for the level of care intended, such as "admit to inpatient" or "admit for observation." Observation services end when the physician or other qualified licensed practitioner orders an inpatient admission, a

transfer to another health care facility, or discharge. The inpatient stay begins on the date and time of the new order.

Inpatient Admissions:

Inpatient admissions are discussed in the Hospital Manual, Chapter 4, page 1:

> Inpatient care is a covered service under the Medicaid Program if it is reasonable and medically necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body member. The service must be consistent with the diagnosis or treatment of the patient's condition and must be rendered in accordance with standards of good medical practice to be considered medically necessary. Inpatient care which does not contribute meaningfully to the treatment of an illness or injury or to the functioning of a malformed body member is not covered.

Inpatient admissions require a physician's order based on his/her evaluation of the patient's needs for medical care. Inpatient admissions are not to be based on the facility's billing needs. The physician must clearly order an inpatient admission in the clinical record. If a physician has not ordered an inpatient admission based on the patient's needs for medical care, a hospital may not bill Medicaid for an inpatient stay. The admission date must coincide with the physician's order and date of physician's order.

Improper activities that may incur retractions upon DMAS (or DMAS contractor) audit:

DMAS (or its contractor) will continue to perform post-payment reviews for inpatient hospital admissions. DMAS (or its contractor) will retract for improper billing related to inpatient admissions and observations. Improper activities that will result in retractions, include, but are not limited to:

- An observation status being changed to an inpatient admission after the patient was discharged.

- An inpatient admission being called an observation status and billed so that it will not be audited by Medicaid.

- Altering physician orders in any way (including, but not limited to the date of the order) from inpatient hospital admission to an observation status or from an observation status to an inpatient admission.

- Admitting a member from a 23-hour observation status to an inpatient admission without a physician's order, or a physician's order that is not in appropriate sequential date order per the medical record.

If DMAS auditors (or contractors) find a pattern of any billing, documentation, or misrepresentation regarding inpatient admissions or observations, it will consider these issues on a case-by-case basis to determine whether a referral to the Medicaid Fraud Control Unit of the Office of the Attorney General is warranted.

VIRGINIA MEDICAID WEB PORTAL

DMAS offers a web-based Internet option to access information regarding Medicaid or FAMIS member eligibility, claims status, check status, service limits, service authorizations, and electronic copies of remittance advices. Providers must register through the Virginia Medicaid Web Portal in order to access this information. The Virginia Medicaid Web Portal can be accessed by going to: www.virginiamedicaid.dmas.virginia.gov. If you have any questions regarding the Virginia Medicaid Web Portal, please contact the ACS Web Portal Support Helpdesk, toll free, at 1-866-352- 0496 from 8:00 A.M. to 5:00 P.M. Monday through Friday, except holidays. The MediCall audio response system provides similar information and can be accessed by calling 1-800- 884-9730 or 1-800-772-9996. Both options are available at no cost to the provider.

ELIGIBILITY VENDORS

DMAS has contracts with the following eligibility verification vendors offering internet real-time, batch and/or integrated platforms. Eligibility details such as eligibility status, third party liability, and service limits for many service types and procedures are available. Contact information for each of the vendors is listed below.

Passport Health Communications, Inc. www.passporthealth.com sales@passporthealth.com Telephone: 1 (888) 661-5657	SIEMENS Medical Solutions – Health Services Foundation Enterprise Systems/HDX www.hdx.com Telephone: 1 (610) 219-2322	Emdeon www.emdeon.com Telephone: 1 (877) 363-3666

"HELPLINE"

The "HELPLINE" is available to answer questions Monday through Friday from 8:00 a.m. to 5:00 p.m., except on holidays. The "HELPLINE" numbers are:

1-804-786-6273	Richmond area and out-of-state long distance
1-800-552-8627	All other areas (in-state, toll-free long distance)

Please remember that the "HELPLINE" is for provider use only. Please have your Medicaid Provider Identification Number available when you call.